## AVMED POS PLAN

**This Schedule of Benefits reflects the higher provider and prescription co-payments for 2014. This is not a contract, it's a summary of the plan highlights and is subject to change. For specific information on Benefits, Exclusions and Limitations please see your Summary Plan Description. FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-68-AVMED (1-800-682-8633), or visit the AvMed website at www.avmed.org/go/mdpht.**

| SCHEDULE OF BENEFITS | COST TO MEMBER | COST TO MEMBER |
|---|---|---|
| | In-Network | Out-of-Network* |
| **LIFETIME MAXIMUM** | Unlimited | Unlimited |
| **CO-INSURANCE LEVELS** | Plan pays 100%;<br>Member Pays 0% | Plan pays 70% of Maximum Allowable Payment (MAP); member pays 30% co-insurance after deductible |
| **CALENDAR YEAR DEDUCTIBLE** | | |
| Individual (per contract year) | Not Applicable | $200 per individual |
| Family (per contract year) | Not Applicable | $500 per family |
| Deductible does not apply toward the Out-of-Pocket Maximum<br>Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan co-insurance; if the family deductible was met prior to their individual deductible being met, their claims will be paid at the plan co-insurance. | | |
| **OUT-OF-POCKET MAXIMUM (Per Calendar Year)** | | |
| Individual Maximum | $1,500 per individual | $1,500 per individual |
| Family Maximum | $4,500 per family | |
| Individual Calculation: Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%. | | |
| **PHYSICIAN SERVICES** | | |
| Services at Physician's offices include, but are not limited to: | | |
| Primary Care Physician's Office Visit | $15 per visit | 30% co-insurance after deductible |
| Specialty Care Physician's Office Visits, Consultant and Referral Physician's Services | $30 per visit | 30% co-insurance after deductible |
| Allergy Injections | No charge | 30% co-insurance after deductible |
| Allergy Skin Testing | $30 per visit | 30% co-insurance after deductible |
| **PREVENTIVE CARE** | | |
| Preventive Care (as required by the Patient Protection Affordable Care Act "PPACA") | No charge | 30% co-insurance after deductible |
| | | |
| **MAMMOGRAM, PSA, PAP SMEAR** | | |
| Preventive care related services (i.e. "routine" services) | No charge | 30% co-insurance after deductible |
| Diagnostic related services (i.e. "non-routine") | Subject to the plan's x-ray and laboratory benefit, based on place of service | Subject to the plan's x-ray and laboratory benefit, based on place of service |

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|---|---|---|
| **SCHEDULE OF BENEFITS** | COST TO MEMBER | COST TO MEMBER |
| | In-Network | Out-of-Network* |
| **INPATIENT HOSPITAL SERVICES** | | |
| Pre-Certification of Hospital Confinements | Handled by admitting physician | Pre-certification required |
| Hospital inpatient care includes: Room and board – unlimited days (semi-private) | No charge | 30% co-insurance after deductible |
| | | |
| Private Room | Limited to the semi-private room negotiated rate | Limited to the semi-private room rate |
| Special Care Units (ICU/CCU) | No charge | 30% co-insurance after deductible |
| Inpatient Hospital Physician's Visits/Consultations | No charge | 30% co-insurance after deductible |
| Inpatient/Outpatient Hospital Professional Services | No charge | 30% co-insurance after deductible |
| **OUTPATIENT FACILITY SERVICES** | | |
| Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room | No charge | 30% co-insurance after deductible |
| Diagnostic Testing | No charge | 30% co-insurance after deductible |
| **EMERGENCY AND URGENT CARE SERVICES** | | |
| PCP's Office | $15 per visit | 30% co-insurance after deductible |
| Specialist's Office | $30 per visit | 30% co-insurance after deductible |
| Hospital Emergency Room | $50 per visit (waived if admitted) | $50 per visit (waived if admitted) |
| Outpatient Professional Services (radiology, pathology, ER physician) | No charge | No charge |
| Urgent Care Facility or Outpatient Facility | $50 per visit (waived if admitted) | $50 per visit (waived if admitted) |
| **LABORATORY/ RADIOLOGY SERVICES** | | |
| (includes pre-admission testing) | | |
| Physician's office visit | No charge | 30% co-insurance after deductible |
| Outpatient hospital facility | No charge | 30% co-insurance after deductible |
| Independent x-ray and/or laboratory facility | No charge | 30% co-insurance after deductible |
| **ADVANCED RADIOLOGICAL IMAGING** | | |
| (i.e. MRI, MRA, CAT scan , PET scan, etc.) The scan co-payment/deductible applies per type of scan per day | | |
| Outpatient Facility | No charge | 30% co-insurance after deductible |
| Inpatient Facility | No charge | 30% co-insurance after deductible |
| Physician's Office | No charge | 30% co-insurance after deductible |
| **OUTPATIENT SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC SERVICES** | | |
| IN \OUT: Limited to 60 visits per calendar year: chiro services, rehab pulmonary, physical, speech, occupational, cognitive, and respiratory therapies combined; 36 visits per calendar year for cardiac rehab. | | |
| Chiropractor | $15 per visit | 30% co-insurance after deductible |
| Physical\ Speech\ Occupational Therapies, Pulmonary Rehab, Cognitive Therapy, Resp.Therapy | $30 per visit | 30% co-insurance after deductible |

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| **SCHEDULE OF BENEFITS** | COST TO MEMBER | COST TO MEMBER |
| | **In-Network** | **Out-of-Network*** |
| **MATERNITY CARE SERVICES** | | |
| Initial visit | $30 per visit | 30% co-insurance after deductible |
| All subsequent prenatal visits, postnatal visits and Physician's delivery charges (i.e. global maternity fee) | No charge | 30% co-insurance after deductible |
| Delivery facility (inpatient hospital, birthing center) | No charge | 30% co-insurance after deductible |
| **DURABLE MEDICAL EQUIPMENT** | | |
| Contract Year Maximum: Unlimited | No charge/ device for DME and Orthotics. External prosthetic appliance in network: no charge after $200 contract year deductible. | Not Covered |
| **ACUPUNCTURE** | Out-of-network coverage only | 30% co-insurance after deductible |
| **MENTAL HEALTH** | | |
| Outpatient | $15 per visit | 30% co-insurance after deductible |
| Inpatient | No charge | 30% co-insurance after deductible |
| Intensive Outpatient | $15 per visit | 30% co-insurance after deductible |
| **SUBSTANCE ABUSE** | | |
| Outpatient | $15 per visit | 30% co-insurance after deductible |
| Inpatient | No charge | 30% co-insurance after deductible |
| Intensive Outpatient | $15 per visit | 30% co-insurance after deductible |
| **DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER** | | |
| Habilitative physical, occupational, & speech therapy services, are covered to a combined maximum of 100 visits per calendar year. | | |
| Applied Behavioral Analysis (ABA) | $15 per visit | 30% co-insurance after deductible |
| Physical, Speech, Occupational Therapy | $15 per visit | 30% co-insurance after deductible |
| **PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY** (**INCLUDES CONTRACEPTIVES) | | |
| Generic | $15 | 30% of charges |
| Preferred Brand | $25 | 30% of charges |
| Non-Preferred Brand | $35 | 30% of charges |
| **SPECIALTY (30-DAY SUPPLY THROUGH SPECIALTY PHARMACY)** | | |
| Generic | $10.00 | 30% of charges |
| Preferred Brand | $16.66 | 30% of charges |
| Non-Preferred Brand | $23.33 | 30% of charges |
| **PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY** (**INCLUDES CONTRACEPTIVES) | | |
| Generic | $30 | 30% of charges |
| Preferred Brand | $50 | 30% of charges |
| Non-Preferred Brand | $70 | 30% of charges |
| **Generic:** medication on the Prescription medication list - **Preferred Brand:** medication designated as preferred on the prescription medication list with no Generic equivalent - **Non-Preferred Brand:** medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list. | | |
| * Member may be responsible for all Out-Of-Network charges in excess of the Maximum Allowable Payment (MAP). | | |
| ** There is no co-payment for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA). | | |